Washington State Department of Health

Washington State Department of Health
Health Professional Loan Repayment Program

For DOH use only
☐ Recruitment
☐ Retention
☐ Both
Entered by _____
Date _____

2007 DENTAL SITE APPLICATION

APPLICATION MUST BE POSTMARKED OR FAXED NO LATER THAN SEPTEMBER 15, 2006

I. SITE INFORMATION

1. Primary site organization name: _____

2. Mailing address: _____
   Street Address/PO Box # City Zip

3. Site name where the provider is (or will be) working: _____
   Name of Clinic/Facility

4. Location of site: _____
   Street City Zip County

5. Site Medicaid Number: _____

II. FACILITY TYPE *(check one)*

☐ Community & Migrant Health Center (FQHC) **(*skip to Section IV*)**
☐ Tribally Operated Clinic **(*skip to Section IV)***
☐ Rural Health Clinic
☐ Hospital-Based Clinic
☐ Hospital-Sponsored Clinic
☐ Private Non-Profit (501 (c) 3 tax-exempt status)
☐ For Profit (no tax-exempt status, such as a proprietary hospital or clinic or private physician's office)
☐ Other Public Organization (one financed by taxes, such as a hospital district)
Describe: _____

III. PATIENT PROFILE DATA

Provide the unduplicated count of total patients and Medicaid patients who obtained care at the site during the most recently available calendar or fiscal year. If your organization operates multiple sites, **provide counts for this site only**, not your total organization. If you do not have actual data, you may provide estimates.

Instructions for New Practices or Clinics: If you are applying for a site that does not have historical data on Medicaid or uncompensated care, you may provide an estimate of service levels for the coming year. If you are providing estimated data, attach a description of what measures the site will take to achieve that level of service (e.g. introduction or increased availability of a sliding-fee discount schedule or increasing access and outreach to Medicaid patients.)

1. Data provided is ☐ Actual ☐ Estimated

2. Data is for month and year ending: _____
Month/Year

3. _____ Total annual dental office visits or patient encounters.

4. _____ Total annual unduplicated active patients.

5. _____ Total annual unduplicated **Medicaid** and Medicaid-like patients.
(Includes: Healthy Options, CHIP, Basic Health and Basic Health Plus)

6. Does this site offer a No-Fee/Sliding-Fee Discount Schedule?
☐ Yes (Include a copy of schedule and policy with this application.) ☐ No

7. _____ **Total** Annual Unduplicated No-Fee/Sliding-Fee Discount Schedule Users.
Include only patients who are pre-approved for a sliding-fee discount schedule. Sliding-fee discount schedule patients are any patients who receive care on a **posted and implemented** sliding-fee discount schedule, ability-to-pay or free of charge basis. This notice must be conspicuously posted near the front desk. Do not include write-offs.

IV. SITE RECRUITMENT NEEDS

This information is used to calculate vacancy rate and to assist in understanding which sites have greater recruitment needs. One FTE = 40 hours of work.

- Current FTE (A): By provider category, complete the filled FTE as of July 1, 2006. Include FTE currently filled by federally affiliated providers such as the National Health Service Corps and providers already receiving state loan repayment. **Do not leave blank.**
- Vacant FTE (B): By provider category, indicate how many of the additional budgeted FTE are or will be vacant at any time between July and December of the current year. This includes all vacancies you are actively recruiting to fill, regardless of whether you are seeking loan repayment assistance for that FTE. Report as FTE – not positions. Write in zero if no positions are vacant. **Do not leave blank.**
- Current FTE and Vacant FTE should equal Total FTE (A+B).
- If you expect current budgeted FTE levels to change over the year, use FTE levels expected at the end of the current calendar year. A budgeted FTE means a FTE for which a budgeted amount has been set aside and is available.

Provider Categories	A FTE Budgeted and Currently Filled	B FTE Budgeted and Currently Vacant	A + B Total FTE
General Dentist			
Dental Hygienist			

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V. PROVIDER PROFILE - RETENTION

(This page may be duplicated as needed. Submit separate page for **each provider type**.)

1. Provider Type *(Check one)*

☐ General Dentist

☐ Dental Hygienist

2. List all providers who will be requesting state loan repayment. Do not include any providers who have already received or are currently receiving funds from the Washington State Health Professional Loan Repayment Program.

Provider Name: _____ Employed on: _____
If this provider was employed after July 1 of this year, how long was the position vacant?
_____ (months/years) ☐ Full Time *(minimum 40 hours per week)*
☐ Part Time (*Hours per week)* _____

Provider Name: _____ Employed on: _____
If this provider was employed after July 1 of this year, how long was the position vacant?
_____ (months/years) ☐ Full Time *(minimum 40 hours per week)*
☐ Part Time (*Hours per week)* _____

Provider Name: _____ Employed on: _____
If this provider was employed after July 1 of this year, how long was the position vacant?
_____ (months/years) ☐ Full Time *(minimum 40 hours per week)*
☐ Part Time (*Hours per week)* _____

VI. PROVIDER PROFILE - RECRUITMENT

(This page may be duplicated as needed. Submit separate page for **each provider type**.)

1. Provider Type *(Check one)*

☐ General Dentist

☐ Dental Hygienist

2. Position is: ☐ Full Time *(minimum 40 hours per week)* ☐ Part Time (*Hours per week)* _____

3. What is the date this position became or will become vacant*?* _____
Month/Year

4. Required qualifications: Provide a brief summary of why the qualifications are necessary to serve your patient population.

☐ Second language proficiency required to serve the clinic population. Reason:_____

_____

☐ Experience or training in working in a multi-cultural setting required to serve clinic population. Reason: _____

_____

☐ Experience or training to serve populations with special needs. Reason: _____

_____

NOTE: The facility administrator will be asked on the provider application to verify the applicant meets all access barriers for which the site received points.

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Agreement

I certify under the Penalty of Perjury that all information included in this application is true and correct to the best of my knowledge and that funds are available to support the positions for which I am applying.

Signature of Facility Administrator _____ Date _____

Print Name _____ Title _____

Contact person for follow-up:

Contact Name _____ Title _____

Phone Number _____ Fax Number _____ Email Address _____

Attachment Checklist

Incomplete applications will not be reviewed.

- ☐ Application (must be complete, signed and dated)
- ☐ Sliding-Fee Schedule (if applicable)
- ☐ Sliding-Fee Schedule Policy (if applicable)

(**Please Fax or Mail – Not Both)**

You can send the completed application and required attachments to:

Nicole Fernandus
Office of Community and Rural Health
PO Box 47834
Olympia WA 98504-7834

OR you may fax the application to:
(360) 664-9273

For assistance contact: Nicole Fernandus (360) 236-2802
or email nicole.fernandus@doh.wa.gov

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